BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of	Docket No. **06A-30004-MDX**
HOWARD L. MITCHELL, M.D.	**Case No. MD-06-0256**
Holder of License No. 30004 for the Practice of Allopathic Medicine in the State of Arizona	**FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR REVOCATION OF LICENSE**

On August 9, 2006 this matter came before the Arizona Medical Board ("Board") for oral argument and consideration of the Administrative Law Judge ("ALJ") Brian Brendan Tully's proposed Findings of Fact and Conclusions of Law and Recommended Order involving Howard L. Mitchell, M.D. ("Respondent"). Respondent was notified of the Board's intent to consider this matter at the Board's public meeting. Respondent did not appear and was not represented by counsel. The State was represented by Assistant Attorney General Anne Groedge. Christine Cassetta, Assistant Attorney General with the Solicitor General's Section of the Attorney General's Office provided legal advice to the Board.

The Board having considered the ALJ's report and the entire record in this matter hereby issues the following Findings of Fact, Conclusion of Law and Order.

FINDINGS OF FACT

1. The Arizona Medical Board ("Board") is the authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 30004 for the practice of allopathic medicine in Arizona.

3. The Board initiated case number MD-06-0256 after receiving a complaint regarding Respondent's care and treatment of a twenty-three year old female patient ("JL"). The complaint alleged Respondent continually over-prescribed inappropriate controlled

substances to JL without a proper diagnosis or consultations even after JL's successful inpatient detoxification for opioid addiction.

4. Included in Respondent's records for JL were records from her gynecologist and anesthesiologist from Texas for the period of November 2002 to August 2003.

5. The gynecologist diagnosed JL with endometrosis, adenomyosis, dysmenorrheal and depression. The medications prescribed by the gynecologist appear to be limited to Lupron and an occasional prescription for Darvocet and NSAID. The gynecologist also discussed with JL acupuncture, chiropractics and vitamins as possible pain management methods.

6. The records indicate JL was referred by her gynecologist to the anesthesiologist for pain management consultation on September 12, 2003 and that JL remained in the anesthesiologist's care for two months.

7. The anesthesiologist noted a two-year history of chronic pelvic pain in the then twenty-one year old JL. JL gave the anesthesiologist a history of having been raped at seventeen years old and identified current symptoms of weight loss, joint pain, depression, anxiety and insomnia in addition to her chief complaint of pelvic pain. The anesthesiologist's impression was "multi-factorial pelvic pain syndrome including endometriosis, complex regional pain syndrome of the pelvic type" and a history of emotional and sexual trauma.

8. The anesthesiologist treated JL with a spinal cord stimulator, but it provided no benefit and caused an increase in her pain complaints. The anesthesiologist also performed a superior hypogastric nerve block, but after transient benefit, JL's pain returned and was more severe than prior to the block. Medication management included Neurontin, but it provided no benefit to JL. Xanax helped JL with her reported obsessive compulsive disorder. The anesthesiologist replaced JL's Narco with Talwin and JL requested an early refill of Norco on November 3, 2003. There are no records of subsequent care provided by the anesthesiologist after November 2003.

9. Respondent initially evaluated JL on December 23, 2003. He noted problems with insomnia, ruminations, helplessness, hopelessness, panic attacks and paranoia. JL had been raped twice during drinking blackouts at ages seventeen and eighteen. JL had problems with pelvic pain, low back pain, endometriosis and adenomyosis. JL's current medications at the time were Percocet bid, Duragesic 25 microgram patch q three days and Xanax 0.5 mg tid. Respondent did not note a psychiatric diagnosis or discernible plan in the initial consultation note.

10. Copies of prescriptions written by Respondent reveal barely legible prescriptions.

11. Respondent's file for JL contained cursory handwritten office notes from January 8, 2004 through March 17, 2006. During this time period Respondent introduced and adjusted various opioid and non-opioid medications for chronic pain and anxiety. JL's chart contained no ordered, sequential listing of medications prescribed either in office notes or in the form of a flow sheet. Respondent's prescribing pattern was deciphered using copies of written prescriptions contained in Respondent's medical records. Examination of these prescriptions identifies a pattern of repeated early refills and escalating dosages of controlled substances.

12. Respondent appropriately obtained a consultation for JL with a spine surgeon who noted that JL's problems were "very minimally spine related."

13. Respondent also appropriately referred JL to a gynecologist. The gynecologist authored a letter to Respondent expressing her opinion that the opioid dosage seemed excessive for the medical conditions and represented a "legal narcotic addiction."

14. Respondent's records do not reflect consideration of opinions of either the spine surgeon or the gynecologist. There appears to be no consideration of the disparity between subjective complaints and the experts' opinions.

15. From the time of Respondent's initial evaluation the escalation and early refills of controlled substances culminate in the October 14, 2005 prescriptions for Soma, MSContin tid.,

a prescription for Oxycontin 80 mg four tid plus two bid pm breakthrough pain (the notation on the prescription is "s/p surgeries and chronic pain"). Respondent did not document what type or when surgeries had been performed, or whether the surgeon was involved in the post-operative pain management. Respondent did not document a rationale for simultaneous use of two different sustained release opioids or for the use of a sustained release opioid for breakthrough pain. If the medication was taken as directed it could result in JL taking a sustained release opioid eight times per day.

16. According to the complaint received by the Board, it was during the time period of late fall 2005 that JL required emergency care on two occasions of seizures. JL then underwent successful inpatient detoxification for opioid addiction from November 16 through 23, 2005. Two weeks later, Respondent wrote prescriptions for escalating dosages of Oxycontin on five occasions between December 6, 2005 and January 17, 2006. This prescribing includes identical prescriptions for #240 Oxycontin 80 mg on two consecutive dates: January 16, 2006 and January 17, 2006.

17. On January 27, 2006 Respondent wrote additional Oxycontin prescriptions despite the fact that if JL had consumed the January 16, 2006 and January 17, 2006 prescriptions for #480 Oxycontin 80 mg she would have taken six times the amount prescribed by him, thus, exhausting a sixty-day supply of Oxycontin in ten days. Without apparent consideration of the severe noncompliance with his prescription instructions and/or the possibility of diversion and without seeing JL, Respondent wrote new prescriptions for a thirty-day supply of Oxycontin 1200 mg per day and Avinza 360 mg ghs on January 27, 2006.

18. Beginning two weeks later Respondent wrote four different thirty-day prescriptions for sustained release opioids at four to seven day intervals, over a seventeen-day period February 2006 without any office visit.

19. In March 2006, within a twenty-four hour time-frame and in the absence of an office visit, Respondent wrote five prescriptions for three different sustained release opioids, three prescriptions for two benzodiazepines, and one prescription for Percocet. Respondent added the benzodiazepines without any apparent precautionary measures to mitigate the potentiation of central nervous system depression. Five days later, JL was treated in the emergency department for acute psychosis and was subsequently transferred by ambulance to an inpatient detoxification center for detoxification for opioid addiction. Respondent has written no additional prescriptions, presumably since JL has been living in a halfway house undergoing treatment for opioid addiction.

20. Physicians are required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient, and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of the treatment. Based on the above Findings, Respondent's medical records for JL are inadequate.

21. The standard of care for treating a patient with chronic nonmalignant pain requires consideration of expert consultants' opinions, patient monitoring, warranted dose escalations, presence of sound pharmacologic principles, and rational polypharmacy.

22. Respondent deviated from the standard of care because he did not consider the opinions of the experts to whom he referred JL, did not monitor JL, prescribed unwarranted dose escalations, did not demonstrate sound pharmacologic principles, and displayed irrational polypharmacy.

23. JL was harmed because she became addicted to opioids, underwent two inpatient opioid detoxifications, underwent emergency treatment for opioid related problems, and serious psychosocial issues were ignored and exacerbated.

24. JL was potentially harmed because she could have overdosed and died after taking the narcotics prescribed by Respondent.

25. In a letter dated April 3, 2006 Patricia Reynolds, Assistant Manager of the Board's Office of Investigations, advised Respondent that an investigation of his care and treatment of JL had been opened. A copy of the complaint was furnished to Respondent. Respondent was requested to provide a complete narrative response to the allegations against him no later than April 19, 2006. Respondent was informed that his failure to timely respond to the request would be an act of unprofessional conduct pursuant to A.R.S. § 32-1401(27)(dd) and (jj). The letter was mailed to Respondent at his address of record with the Board.

26. Respondent failed to file a complete narrative response to the complaint.

27. On April 21, 2006 Case No. MD-06-0256 came on for discussion before the Board. After deliberations the Board found that the facts presented demonstrated that the public health, safety or welfare imperatively required emergency action. The Board concluded that Respondent's conduct constituted unprofessional conduct in violation of A.R.S. §§ 32-1401(27)(e); 32-1401(27)(j); 32-1401(27)(q) and 32-1401(27)(ll). The Board ordered Respondent's license to be summarily suspended pending formal hearing before the Office of Administrative Hearings, an independent agency.

28. On May 11, 2006 the Board's Executive Director issued the Notice of Hearing in this matter. A copy of the Notice of Hearing was mailed to both Respondent's business address and his home address.

FINDING OF IMMEDIATE EFFECTIVENESS

29. It is necessary for this decision to take immediate effect to protect the public health and safety and a rehearing or review is contrary to the public interest. A.A.C. R4-16-102(B).

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over Respondent and the subject matter in this case.

2. The Board had the burden of proof in this matter. A.R.S. § 41-1092.07(G)(2). The standard of proof is a preponderance of the evidence. A.A.C. R2-19-119(A).

3. The conduct and circumstances described in the above Findings constitute unprofessional conduct by Respondent in violation of A.R.S. § 32-1401(27)(e) ("failing or refusing to maintain adequate records on a patient").

4. The conduct and circumstances described in the above Findings constitute unprofessional conduct by Respondent in violation of A.R.S. § 32-1401(27)(j) ("prescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes").

5. The conduct and circumstances described in the above Findings constitute unprofessional conduct by Respondent in violation of A.R.S. § 32-1401(27)(q) ("any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public).

6. The conduct and circumstances described in the above Findings constitute unprofessional conduct by Respondent pursuant to A.R.S. § 32-1401(27)(ll) ("conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.")

7. The conduct and circumstances described in the above Findings support the Board's emergency action summarily suspending Respondent's license to protect the public health, safety or welfare. A.R.S. § 32-1451(A).

ORDER

Based upon the Findings of Fact and Conclusions of Law as adopted, the Board hereby enters the following Order:

Respondent's license No. 30004 to practice allopathic medicine in the State of Arizona is revoked on the effective date of this Order and Respondent shall return his wallet card and certificate of licensure to the Board.

RIGHT TO APPEAL TO SUPERIOR COURT

Respondent is hereby notified that this Order is the final administrative decision of the Board and that Respondent has exhausted his administrative remedies. Respondent is advised that an appeal to Superior Court in Maricopa County may be taken from this decision pursuant to Title 12, Chapter 7, Article 6.

Dated this 11th day of August, 2006.

(SEAL)

ARIZONA MEDICAL BOARD

By: _____
Timothy C. Miller, J.D.
Executive Director

Original of the foregoing filed this 11th day of August 2006, with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Copy of the foregoing filed this 11th day of August 2006, with:

Cliff J. Vanell, Director
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Executed copy of the foregoing mailed this 11th day of August, 2006, to:

Howard L. Mitchell, M.D.
(address of record)

Executed copy of the foregoing mailed this____ day of August, 2006, to:

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